



CANNON BUILDING  
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STATE OF DELAWARE  
DEPARTMENT OF STATE  
DIVISION OF PROFESSIONAL REGULATION  
**Board of Podiatry**

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: DPR.DELAWARE.GOV

## Employment Verification Form

### SECTION A: APPLICANT INFORMATION – to be completed by applicant

If an applicant for podiatric licensure by reciprocity is licensed in a state where the licensure standards are not substantially similar to those of Delaware, the applicant must provide the Board with an affidavit from his/her employer(s) in the state of licensure, or other evidence acceptable to the Board, documenting at least five years of practice after licensure in that state (Section 4.4 of the Board's Rules and Regulations). Use this form to document each period of employment during the required five years of podiatric practice. Complete Section A and send a copy of the form to each employer. (For periods of self-employment, provide tax forms or a business license to document your self-employment.)

Applicant Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### AUTHORIZATION FOR RELEASE OF INFORMATION

As an applicant for licensure in the State of Delaware, I authorize release of information about my Podiatric employment.

**APPLICANT SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION B: EMPLOYMENT INFORMATION – to be completed by employer in presence of notary

1. Name of Practice Where Applicant Employed: \_\_\_\_\_
2. Mailing Address: \_\_\_\_\_  
\_\_\_\_\_
3. Phone: \_\_\_\_\_ 4. Email: \_\_\_\_\_
5. Name of Person Providing Verification: \_\_\_\_\_
6. Title: \_\_\_\_\_
7. The employee named in Section A worked at this practice from \_\_\_\_\_ to \_\_\_\_\_  
Start Date End Date
8. This employment was in the State of \_\_\_\_\_.

**SIGNATURE OF EMPLOYER REPRESENTATIVE:** \_\_\_\_\_ Date: \_\_\_\_\_

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, in the year of \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary

SEAL

**Employer – Please mail completed, signed, notarized form to Board of Podiatry at address above.  
The Board office will accept only forms it receives directly from the employer.  
Forms returned by the applicant will not be accepted.  
Faxed forms will not be accepted.**